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| AUTHOR | Kjerland, Linda; Eide, Kathleen Corrigan |
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ABSTRACT

This booklet presents principles of Project DAKOTA, a demonstration project to provide services to infants and young children with disabilities via their families and community. Project goals are listed, including a focus on those needs considered essential by parents and the use of natural settings and resources for intervention. Guidelines are listed that enable parents to be involved at all steps of the intervention process. The document encourages the utilization of family and community resources, with staff resources seen as a supplement. The choice of a transdisciplinary team structure is suggested because of its portability, potential for staff development, better continuity of services, and holistic view of the child. A chart contrasts the traditional individualistic style of service delivery versus the transdisciplinary family/community-centered approach of this project. Finally, the project's five steps are summarized, including: (1) planning the assessment with families; (2) planning the assessment with staff; (3) assessment; (4) discussing the assessment; and (5) determining goals, strategies, and service settings. Among evaluation findings are: 83 percent of goals concerning child change were originated by parents; 100 percent of infants and preschoolers had weekly contact with nondelayed peers; and children gained an average of 10 days/month over and above gains predicted by pre-program developmental rates. (DB)

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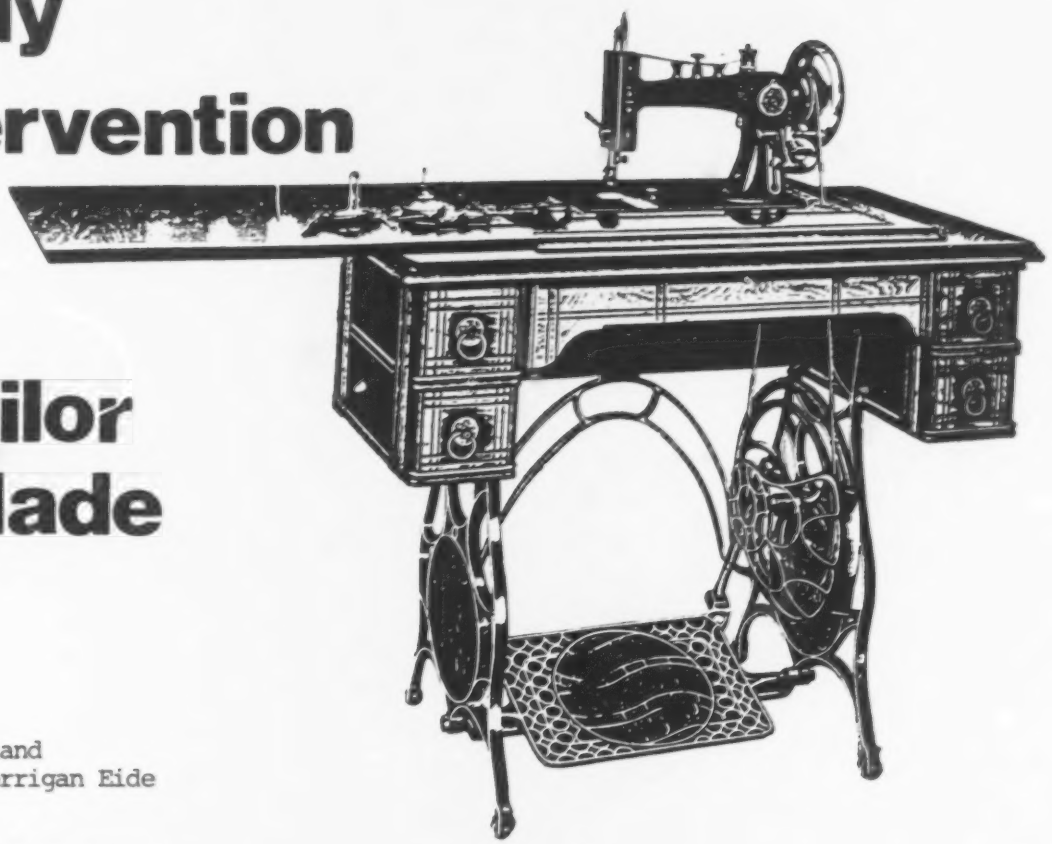
# Project DAKOTA

# Early Intervention Tailor Made



EC 300736

Linda Kjerland
Kathleen Corrigan Eide

Project Dakota Outreach
680 O'Neill Drive
Eagan, Minnesota 55121
(612) 455-2335

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DAKOTA

Assisting the community
and people challenged by disabilities
to live and work together

680 O'Neill Drive
Eagan, MN. 55121
(612) 455-2335

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## Project DAKOTA

Project DAKOTA was a U.S. Department of Education, Handicapped Children's Early Education Program, Demonstration model awarded to DAKOTA, Inc. from 1983 to 1986. The Project team consisted of a director, speech/language clinician, occupational therapist, teacher, family services counselor, and program assistant.

## Project DAKOTA Outreach

In 1986 and again from 1988-1991 Project DAKOTA was awarded an Outreach grant from the U.S. Department of Education to provide training and technical assistance.

## Mission Statement

DAKOTA, Inc. is a private, non-profit agency which served newborns to preschoolers with delay or disability in Dakota County, Minnesota. The agency mission for early intervention is to assist the family and community to promote optimal development of the child and reduce the negative effects of delay or disability. DAKOTA, Inc. adopted the Project DAKOTA model.

Material in this hand-out was developed in part with funds from the U.S. Department of Education. Points of view or opinions expressed herein do not necessarily represent official Department of Education position or policy.

## WHY TAILOR MADE?

"Interventions that are not individualized for each child and family may be more harmful than helpful."

Arthur Parmalee 1978

"Copernicus came along and made a startling reversal--he put the sun in the center of the universe rather than the Earth. His declaration caused profound shock. The earth was not the epitome of creation; it was a planet like all other planets. The successful challenge to the entire system of ancient authority required a complete change in philosophical conception of the universe. This is rightly termed the "Copernican Revolution."

"Let's pause to consider what would happen if we had a Copernican Revolution in the field of disability. Visualize the concept: the family is the center of the universe and the service delivery system is one of the many planets revolving around it. Now visualize the service delivery system at the center and the family in orbit around it. Do you see the difference? Do you recognize the revolutionary change in perspective? We would move from an emphasis on parent involvement (i.e. parents participating in the program) to family support (i.e. programs providing a range of support services to families)."

Turnbull, Summers 1985

"Much of the emotional distress observed in parents of handicapped children can be accounted for by lack of information and skills."

Matheny, Vernick 1969

"The role of the family is not an educational extension of the intervention program. Rather, the opposite is true, the intervention program should be an extension of the family."

Wright, Granger and Sameroff 1984

"There are a thousand and one combinations of how you can do it, and the parent has the yes or no about it all. ...If you are working like you should be, I'm the conductor pulling it all together. I'm the one to say stop and go and that's too much of this or that. Then we'll harmonize really well."

Sharyl Horbal 1985
Parent in Project Dakota

## PROJECT DAKOTA GOALS

- Focus on the child and family needs considered essential by parents.
- Insure direct and meaningful collaboration among parents and staff throughout the intervention process.
- Promote the acquisition of knowledge, skill and confidence by parents to describe their child's strengths and needs and to identify and carry out goals and strategies for their child.
- Encourage and transmission of these strategies by parents to other caregivers and settings.
- Increase the child's ability to function in less restrictive environments. Draw upon natural settings and resources for intervention.

## TO MEET THESE GOALS WE NEEDED TO EXAMINE OUR VALUES

We agreed with Lisbeth Vincent that parents:

- generate creative and innovative solutions
- are the best and most committed long-term advocates
- want the leadership and want to determine what is best.

We adopted the guidelines from Rose Bromwich in Working with Parents and Infants: An Interactional Approach

1. Enable parents to remain in control.
2. Avoid the 'authority-layman' gap.
3. Deal with parents' priorities and concerns.
4. Build on parents' strengths.
5. Respect parents' goals for their infant.
6. Involve parents in planning.
7. Respect individual styles of parent-infant interaction.
8. Reinforcement is not enough - provide the how and why.
9. Give parents an 'out'.
10. Share how it feels to get no response (with infant).

We were aided by Gerald Caplan's The Theory and Practice of Mental Health Consultation. He describes the role of consultant (which we call 'staff'), consultee (which we call 'parent'), and client (which we call 'child').

> "This side by side joint wrestling with the complexities of the client ... is the basis for an appropriate relationship between consultee and consultant. It provides the consultee with expert help and support as the contributor of important information upon which the understanding of the client is to be based."

We saw parents as key to the intervention content and methodology. We revamped our attitudes, assumptions and services to become responsive to parents' priorities and active decision-making.

## WE TOOK A NEW LOOK AT OUR RESOURCES *

### Family Resources

- Families govern their investment of time and energy; there is no "hidden agenda" to increase or alter it. The goal is to have their current commitment fit their current energy, schedules, and priorities.

- Intervention strategies can be a natural part of the daily routine and fit comfortably into the interactions and styles of family members.

### Community Resources

- Families should be offered on-going information and assistance in using community resources so they may make informed decisions about what is available and whether it may play a role in their efforts.

- Settings used by non-delayed peers should be used in preference to specialized or segregated settings.

### Staff Resources

- Staff resources should supplement, not supplant, family and community resources.

- Consultation and assistance should be available in the settings where the skills will be used or practiced.

* Project Dakota Operating Principles

## WE NEEDED TO EXAMINE OUR TEAM STRUCTURE

There are many choices for how to structure a team. Each has benefits and challenges. We chose transdisciplinary teamwork. This chart explains how it differs from two other team structures.

Multidisciplinary

Requires multiple disciplines, recognizes important contribution of each discipline; assessment, planning, and implementation are done separately by each discipline. Disciplines work independently of each other.

Interdisciplinary

Requires multiple disciplines; recognizes importance of contributions of each discipline and that joint planning will enhance services; each discipline conducts their own assessment and implementation in their discipline area but works from a common, jointly developed IPP.

Transdisciplinary

Requires multiple disciplines; the parent is an official member of the team; sees that each has important contributions and that active teaching and learning across disciplines will enhance services. Assessment, planning, and implementation are collective efforts. Implementation is predominantly carried out by one staff member through active consultation from the other disciplines.

We chose Transdisciplinary team-work because it offers--

Portability - Staff expertise is channeled primarily through one person who can then more easily move into community settings and respond to familily schedules.

Staff Development - On-going teaching and learning across discipline boundaries occurs through extensive child-specific consultation.

Continuity - Parent and facilitator communication is more comprehensive and less fragmented than having parents individually relate to many team members throughout the week. There is greater continuity for the child/infant as well; they relate to one staff person versus many throughout the day or week.

Wholistic View of Child - Programming is based on the integration of strengths and needs in all areas of development including disposition, personality characteristics, and behavior.

## WE ALTERED OUR PROCESS

| Our Old Way | Our New Way |
|---|---|
| 1. Each staff plans their assessment of their developmental area. | 1. Planning the assessment<br>a. The facilitator asks the parents for priorities/questions they wish to be addressed in the assessment.<br>b. The facilitator then shares this with other team members who help plan a comprehensive assessment that focuses on issues raised by parents. |
| 2. Each staff conducts their own assessments if possible at a time when a parent can be present so that each assessment can be discussed with the parent. This usually means 3 - 5 assessment sessions. | 2. The assessment is scheduled when parents can be present; only the facilitator and parent interact with the child while other staff on the team observe and record. |
| 3. Each staff summarizes their assessment findings, and recommends goals and treatment settings at a meeting of staff. These staff recommendations are shared with parents at the planning conference. | 3. Immediately after the assessment, the parents share what they have seen during the assessment: their child's strengths, interests, motivators, challenges, and frustrations. Staff elaborate on these observations and together with parents produce a complete and practical description of the child. |
| 4. Parents are asked if they agree with the recommended goals or have other goals. Staff share their recommended approaches tomeet each goal. | 4. Next, parents draw conclusions or state what seems most important to them regarding the child and define major goals. Staff supplement as needed and accepted. (Typically there are 2 to 4 goals.) |

| Our Old Way | Our New Way |
| --- | --- |
| 5. To carry out the goals, a primary service setting is chosen by the team. (Generally, either home-based for infants and toddlers or center-based for preschoolers.) | 5. To carry out the goals, strategies are created which draw upon adults and children encountered by the child throughout the day. Supporting contact with non-delayed peers is given priority. |
| 6. Each staff provide direct service or consult in their area of development as needed, and plan the center-based services; parents reinforce goals in activities at home. | 6. The facilitator consults with family and community resources to carry out the plan, and provides direct service when it can not be accomplished through consultation. The other staff remain accountable for their area of expertise through active consultation with the facilitator. |
| 7. Every few months the plan is reviewed and sometimes revised; reassessment and planning occurs annually. | 7. The plan is reviewed and revised monthly; reassessment and planning occurs every four months. |
| 8. Success is measured by:<br>- child progress | 8. Success is measured by:<br>- child progress.<br>- parent satisfaction.<br>- staff responsiveness to parents' needs and concerns.<br>- integrated versus segregated service settings and contact with non-delayed peers.<br>- parents' gains in knowledge, skill and confidence in describing their child, setting goals, and carrying out strategies. |

## OUR PROCESS IN DETAIL

Step One: Planning the Assessment with Families: Each parent and major caregiver receives a questionnaire. From the discussion generated by this step, the family and facilitator begin to plot out the assessment activities, materials and what to look for.

### WE ASK THEM ABOUT CONTENT:

"I describe my relationship with my child this way..."

"A typical day with my child includes..."

"When around other children, my child..."

"My child likes/is really good at..."

"My child needs help with/ avoids..."

"My child and family together like to..."

"Recent progress or changes are..."

"Questions I have..."

"My child does best when..."

"I would like my child to learn to get better at..."

"To help my child, I would like help with..."

### WE ASK THEM ABOUT THE PROCESS:

"Where should the assessment take place?"

"What time of day (when the child is alert and working parents can be present)?"

"What are favorite activities or toys that help keep the child focussed, motivated, comfortable?"

"Who should interact with the child and what will be the roles of facilitator and parents:
-sit beside child
-assist in activities to explore abilities
-offer comfort and support to child
-exchange ideas with facilitator
-permit facilitator to handle/ carry out activities with child"

"May I observe your child in other settings?"

Step Two: Planning the Assessment with Staff

- o After the visit with the family, the facilitator schedules and leads a meeting of staff to share the family's assessment priorities and suggestions.
- o The staff then continue the assessment preparations begun by the family and facilitator. They do so in 3 ways:
  - · contribute ideas within and across disciplines
  - · collaborate with one another to generate materials, activities, and what to look for and
  - · insure that the assessment is comprehensive while focussing on family concerns and priorities.
- o The listing of materials, activities, and what to look for (started by family and facilitator and extended by the rest of the staff) becomes a guide for observations during the assessment.
- o Individual staff are accountable for contributing within and across disciplines. Staff consult with each other on techniques and observation skills that will support the facilitator in carrying out the assessment.

Step Three: Assessment

- o The desired mood is relaxed, informal, and comfortable. Interactions flow between facilitator-parent, parent-child, facilitator-child. Adjustments, adaptations and on-the-spot problem-solving are encouraged.
- o The facilitator, parent(s), and child interact together to carry out the assessment. The rest of the team quietly observes and records the child's skills and behavior throughout all areas of development.
- o The assessment lasts from 30 to 60 minutes depending upon the age and energy of the young child.
- o It represents the priorities and particulars of the child, the family, and the environment.

Similar methods of assessment have been called arena, open-field, and transdisciplinary. We call this method 'tailored' because each assessment is unique.

## Step Four: Discussing the Assessment

### Evaluating the Assessment

Immediately after the assessment, parents, and staff share what they learned about the child. The facilitator beings by asking the parent:

"How did you feel about the assessment?"

"Any surprises or was it typical of your child?"

"What should we do differently next time?"

Staff follow with their impressions as well.

### Focus on Strengths/Interests/Motivators/Progress

The facilitator first asks the parents:

"What did she do well, easily?"

"Where has she made progress?"

"What does he love to do, get excited about?"

Staff expand upon and supplement this listing so that discussion flows among all the team members to integrate points of view.

### Focus on Needs/Frustrations of Child or Others/Difficulties

"What behaviors concern you?"

"Where did you see her having difficulty?"

"When did you see him get frustrated?"

"What are other times or things that frustrate him?"

Staff expand upon and supplement this listing, again, so that discussion flows back and forth among all the team.

## Drawing Conclusions

According to our commitment to see the whole child and the context of their environment, we ask parents to consider the list of strengths and needs together by asking questions such as:

"What seems most important?"

"What stands out now?"

"What comes to mind?"

This permits the team to hear the overall impression or position of parents. This is recorded and is reflected upon when addressing goals.

## Reviewing Current Status of Peer Contact

Parents and staff agree to a statement that describes the child's current contacts with non-delayed peers.

## Reviewing Current Key Environments

Parents and staff list environments where the child currently spends time or which are of particular importance to the child/family.

## Major Goal Areas

This meeting concludes with a list of one, two, or three priorities that parents have for their child. A meeting with parents and facilitator is scheduled to work out the details of how they will be addressed.

## Step Five: Determining Goals, Strategies, and Service Settings

### Goals

Goals describe desired child change to pursue over the next few months.

> "What do you want changed?"
> "What should we work on now?"
> "What would be most helpful for you?"

Goals, typically 2 to 4, are derived from families and therefore reflect their priorities. Goals suggested by staff are added with parents' approval.

For each goal, consensus is reached about what the child and adults are doing now and what may be the result or benefits in change.

### Strategies

Strategies specify how family members, staff, and others will help the child reach goals. We seek parents' ideas about strategies.

> "What do you think you or others could try?"
> "What might work in your household, at the babysitters, or in the nursery?"
> "What does the child do already that we can build on?"

Staff expand upon and generate strategies as well. The team records who will carry out the strategies and who will help those persons learn to carry them out.

### Settings

In the strategies section, it is specified where each strategy will take place, i.e. home, nursery school, etc., and sometimes in-center. To further promote contact with non-delayed peers we ask parents:

> "Are there children next door, in the apartment buildings, or at church for your child to play with?"

We discuss what help the facilitator can provide to parents and others in community settings to help the child meet and succeed in play with these peers.

## SERVICE MENU

This menu is designed to stimulate thinking about the many ways services can be made available to families. Please don't let choices be limited to these! Families and staff may draw from all three categories in any combination. Subsidies and transportation assistance are available for community group settings. Preference is given to settings with non-delayed peers.

### In the Child's Home

with:
- ___one parent
- ___both parents
- ___and siblings
- ___and other family members

where:
- ___family home
- ___EI center
- ___other locations requested by family
- ___via telephone

time of day:
- ___a.m. ___p.m. ___eve

day of week:
- ___(Monday-Friday)

Frequency:
- ___1x month
- ___2x month
- ___1x week
- ___2x week
- ___3x week

### In the Community

locations:
- ___parent-child group
- ___family daycare
- ___neighborhood playmates with staff help
- ___church group/program
- ___recreation program
- ___group lessons such as tumbling, dance, swim
- ___nursery school, daycare
- ___other:

facilitator role:
- ___full assistance with child
- ___partial assistance with child
- ___consultation to group teacher
- ___consultation with family who carries out assistance or consultation with group teacher

### At the Center

Parent-child Play Groups

___a.m. ___p.m. ___early evening

___1x month ___2x month ___1x week ___2x week

Child Groups
- ___small, non-integrated group
- ___peer tutors (non-delayed older peers)
- ___one to one

___1x week ___2x week

Family Events
- ___siblings
- ___grandparents
- ___support or coffee groups
- ___family retreats
- ___parent discussions

## SELECTED FINDINGS

### IPP Participation

83% of goals have parents as the source; goals describe desired child change

40% of strategies have parents as the source; strategies specify "how to's"

4% of strategies are carried out by staff only

41% of strategies are carried out by family members only

38% of strategies are carried out by extended family or community members such as babysitters or nursery schools

20% of strategies are carried out by family, community, and staff

### Natural Settings and Resources

100% of infants and preschoolers had contact each week with non-delayed peers.

Average Hours of Contact with Non-Delayed Peers: May, 1986
18.5 hours per week.

### Networking

Families were provided information or helped to utilize an average of 8.5 community resources such as respite, financial assistance, diagnostic clinics, counseling, and early childhood programs.

### Child's Developmental Gains

Children experienced an average of 10 days/month developmental gain over and above gains predicted by the pre-developmental rates.

Jo Ann Kovach, Program Evaluator

## PROJECT DAKOTA OUTREACH

Training and assistance is available to communities and program parents and professionals who are creating, expanding, or enhancing their early intervention efforts. Project Dakota consultants specifically assist programs in achieving family centered and community based services via staff and parent in-services, consultations, and program evaluation. Content areas include:

- Collaboration with Families for Responsive Programming
- Individualized Family Service Planning
- Transdisciplinary Teamwork
- Integration and Inclusion for Children Birth to Five

## Products Available

Many products are available. Write or call for an order form.

- 90 page final report ($12.00)
- 86 page manual for assessing parent satisfaction ($18.00)
- additional copies of this booklet ($3.00 or $2.50 each for orders of 20 or more)
- 20 page paper on the evolution of Dakota's philosophy and practices for responsiveness to families ($5.00)

Project Dakota
DAKOTA, Inc.
680 O'Neill Drive
Eagan, Minnesota 55121

(612)455-2335 or (612)454-2732

Linda Kjerland, Director
Jean Mendenhall, Training Coordinator
Kathleen Corrigan Eide, Training Associate

1109K-2